

The Legal Structure of Mental Health Services

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INTRODUCTION

The way in which mental health services are organised, delivered and regulated has been reorganised many times in recent years. The purpose of this article is to summarise the present position, and it is informative, rather than analytical. The service changes are dealt with in the following order:

- A The National Health Service
- B The Provision of Social Care
- C The Provision of Independent Healthcare
- D Maintaining Quality Standards

A. THE NATIONAL HEALTH SERVICE

In essence, the NHS has four components:

- The Department of Health (including its executive agencies and regional offices/directors).
- NHS bodies and individuals which commission or provide services, or do both (e.g., Health Authorities, Primary Care Trusts, NHS trusts and general practitioners). They are part of the National Health Service, but not part of the Department of Health. However, the Secretary of State controls their activities through the giving of directions, the making of appointments, the issue of health service circulars, and so forth.
- Independent organisations and institutions that provide services to the NHS through arrangements entered into with NHS bodies (e.g., 'private hospitals and clinics').
- Quasi-autonomous, non-departmental public bodies such as the Commission for Health Improvement ('quangos'), that fulfill advisory or executive functions, and are accountable to the Department of Health.

The Health Act 1999 created a new duty of co-operation within the NHS, and NHS bodies are expected to work together to deliver the NHS Plan.

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Tribunals – Law and Practice' (Sweet and Maxwell 1997)

The Department of Health

The Secretary of State has overall responsibility for the Department of Health, and he is accountable to Parliament for the National Health Service in England. He is supported by two Ministers of State and by three Parliamentary Under Secretaries of State.

The Department's funding is negotiated annually with the Treasury, through the public expenditure survey. The sum available for hospital and community health services current spending in 2000/01 was £35,716m.

Section 1 of the National Health Service Act 1977 imposes a broad duty on the Secretary of State to ensure the provision of a health service.

So far as mental health services are concerned, it is the Secretary of State's duty to continue to promote a comprehensive health service designed to secure improvement in the mental health of the people of England and Wales; and, for that purpose, to provide or secure the effective provision of services in accordance with the 1977 Act.

More specifically, the Secretary of State has a duty to provide hospital accommodation and such facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness, as he considers are appropriate as part of the health service, and to such extent as he considers necessary to meet all reasonable requirements.

Although responsibility for securing that these services are provided to patients rests with the Secretary of State, he has delegated most of his functions to local Health Authorities.

NHS Executive

The NHS Executive is headed by a Chief Executive and has a departmental board. The most senior civil servant in the department combines the roles of Permanent Secretary to the Department of Health and Chief Executive of the NHS Executive. He reports directly to the Secretary of State.

The NHS Executive works with ministers to develop health policies, and is responsible for giving hospital chief executives, staff and health service agencies information and guidance concerning their implementation.

The board is supported by directors, each of whom has responsibility for leading work on certain departmental priorities. There is a Directorate of Public Involvement, Nursing, Mental Health, Disability and Allied Health Professions.

Functions of Department of Health

The Government paper, *'Shifting the Balance of Power within the NHS: Securing Delivery'*, published in 2001, set out a long-term programme aimed at changing the culture and practices of the NHS, by moving power away from central government. NHS bodies will be expected to devolve more decision-making power to frontline staff, patients and the local community.

According to *'Shifting the Balance of Power'*, the Department of Health will change its working pattern, by withdrawing from aspects of performance management, and focusing on the delivery of the NHS Plan and the development of the NHS. Its key functions will include:

- Responsibility for overseeing the development of the NHS and social care.
- Managing the appointment and development of senior management staff.
- Supporting Ministers.
- 'Troubleshooting'.

NHS regional offices

The size and complexity of the NHS means that the NHS Executive operates through a regional structure. However, the NHS Executive's regional offices will be abolished in April 2003. From then onwards, four regional directors of health and social care will oversee the development of the NHS, and provide a link with the centre.

The four new regional directors will cover London, the South, the Midlands and the North, with the outer boundaries of each region being coterminous with the Government Offices of the Regions.

It is not intended that the new regional directors will simply replace the regional offices. They will be more clearly part of the Department of Health, and take a more strategic role, as performance management is devolved to the new Strategic Health Authorities (see below). The key functions of the new directors will include:

- Responsibility for overseeing the development of the NHS and social care. This includes ensuring the integration of health and social care planning, and the implementation of the flexible arrangements allowed for by the Health Act 1999, and supporting the development of care trusts.
- Supporting the Chief Executive, the Chief Operating Officer, and the Chief Inspector of Social Services in assessing performance. This includes ensuring that NHS and social services are integrated, and overseeing the targets in local authorities' Local Public Service Agreements.
- Managing the appointment, development and succession planning of senior management staff.
- Supporting Ministers through casework, Ministerial visits and local intelligence.
- Troubleshooting.

Executive agencies

Executive agencies are self-contained units established to improve management in government. They carry out specific executive functions on behalf of the parent department within an operational framework agreed by Ministers. Although they have discrete responsibility for particular business areas, they are still part of the Department, and accountable to it.

The Department of Health has six executive agencies:

EXECUTIVE AGENCIES	
Health Development Agency	Previously the Health Education Authority. It provides the evidence for health improvement, sets standards for public health practice, and advises on the capacity and capability of the public health workforce.
Medicine Devices Agency	Oversees the safety, quality and performance of medical devices.
Medicines Control Agency	Safeguards public health by ensuring that all medicines on the UK market meet appropriate standards of safety, quality and performance.
NHS Estates	Supports the provision of high-quality NHS buildings and facilities
NHS Pensions Agency	Looks after the pension needs of NHS staff.
NHS Purchasing & Supply Agency	Provides expertise in purchasing and supply matters for the NHS.

Non-departmental public bodies ('quangos')

Non-departmental public bodies are set up when ministers feel that particular work needs to be done without the direct influence of government departments.

Various terms are used when naming these public bodies, although the terminology is inexact. They may be described as an inspectorate (if services are inspected); as a commission (if a body of persons is authorised to inquire into certain facts or services); as an agency (if it is not independent, and acts as a department's agent); as a regulatory body (if it regulates the conduct of a profession or business); as a council (if it is intended to be representative); or as an advisory body (if it has no powers). The powers conferred on them vary considerably, and depend on the body's functions. For example, advisory bodies need no powers.

Non-departmental public bodies and non-provider special health authorities employed 14,780 staff in 1999/2000, and received almost £715m in public funding. The Mental Health Act Commission employed 32 of the 14,780 staff, and received just over £3m of the £715m of public funding.

The NHS Plan

In July 2000, the Government published '*The NHS Plan: A plan for investment, A plan for reform*', in which was set out a ten-year plan for the reform of the health service in England. The NHS Plan is the Government's blueprint for the National Health Service.

Action has since been taken to implement many elements of the plan. Many of the proposals requiring legislation were included in the Health and Social Care Act 2001, and others form part of the National Health Service Reform and Health Care Professions Bill introduced in November 2001.

The clinical priorities set out in the plan include the following:

- 1,000 graduate primary care mental health workers to be employed to help GPs manage and treat common mental health problems.
- 500 more community mental health staff to be employed to work with GPs and primary care teams, NHS Direct, and in A&E departments.
- 50 early intervention teams to be established to provide treatment and active support in the community to young people and their families.
- 335 crisis resolution teams to be established within three years.

By 2004:

- all young people who experience a first episode of psychosis to receive the early and intensive support they need.
- all people in contact with specialist mental health services to be able to access crisis resolution services.
- women-only day centres in every health authority.

NHS Trusts

Section 5 of the National Health Service & Community Care Act 1990 Act provided for the establishment of semi-autonomous bodies known as NHS trusts. These bodies were created to assume responsibility for the ownership and management of hospitals and other facilities previously managed by local Health Authorities. Health Authorities and Primary Care Trusts sign service agreements with NHS trusts for the provision of hospital and community health services.

As amended by section 13 of the Health Act 1999, section 5(1) now provides that NHS trusts are established to provide goods and services for the purposes of the health service. Furthermore, the order establishing the trust may impose on it a duty to provide particular goods or services at or from particular hospitals, establishments or facilities. The Secretary of State may therefore specify that a trust must provide a particular service, such as an ambulance service, from a particular site or sites.

NHS trusts are established by statutory instrument, and the establishment order specifies the trust's functions. These functions will include any statutory functions under the Mental Health Act 1983. Trusts should appoint a committee to undertake the hospital managers' statutory duties under the Mental Health Act 1983.

The 1999 Act gave the Secretary of State a general power to give directions in respect of an NHS trust's full range of statutory functions. Previously, NHS trusts enjoyed a substantial degree of autonomy. Trusts are required to carry out their functions 'effectively, efficiently and economically,' and to comply with directions given to them by the Secretary of State.

Every NHS trust is a body corporate, having a board of directors which consists of a chairman appointed by the Secretary of State and executive and non-executive directors (that is to say, directors who respectively are and are not employees of the trust). All of the trust's directors are full and equal members of the Board, and jointly responsible for carrying out the functions of the trust.

NHS trusts continue to provide most secondary care and specialist services in hospitals. Nearly all the hospitals in England are now vested in NHS trusts, although smaller community hospitals are increasingly being run by Primary Care Trusts.

At the beginning of 2000, there were 373 NHS trusts in England responsible for managing the provision of hospitals, community health and ambulance services.

Health Authorities

The entire area of England is covered by Health Authorities. On 1 April 2002, the pre-existing 95 health authorities were merged to form 28 larger Strategic Health Authorities.

The new authorities cover an average population of around 1.5 million, and are funded in a similar way to Special Health Authorities (such as the Mental Health Act Commission and NICE).

The function of the new 'Strategic Health Authorities' is different from that performed by their predecessor bodies. Under the new arrangements:

- Primary Care Trusts (see below) are the lead NHS organisations. Revenue allocations will be made directly to them, and incentives will reward devolution to frontline teams. They will assess need, plan and secure all health services, improve health in their localities, provide most community services and develop primary care services. NHS trusts will continue to provide most secondary care and specialist services in hospitals.
- The Strategic Health Authorities will provide strategic leadership and seek to ensure that NHS organisations work together to deliver the NHS Plan and the devolution agenda. They will be expected to foster trust autonomy, to encourage trusts to empower clinical teams, and to develop a culture of decision-making as close to communities and patients as possible.
- PCTs and NHS trusts will be accountable to the Strategic Health Authorities, and performance managed by them through performance agreements that focus on the areas with greatest clinical priority, including mental health.
- Strategic Health Authorities will, in turn, account to the Secretary of State for the performance of the NHS in their area. Annual delivery agreements between them and the Department of Health will set out the progress expected against the NHS Plan. These will build on the performance agreements with individual PCTs and NHS Trusts.

Special Health Authorities

Under the National Health Service Act 1997, the Secretary of State may establish special health authorities for the purpose of performing any functions which he may direct the body to perform on his behalf.

Some NHS services are administered by special health authorities, which are accountable directly to the Health Secretary. Examples include the Mental Health Act Commission and the National Institute for Clinical Excellence (NICE).

Primary Care Trusts

The Health Act 1999 provided for the establishment of new bodies called Primary Care Trusts, which constitute a new tier of administrative body below Health Authorities.

On 1 April 2002, local primary care trusts (PCTs) effectively took over the responsibility of commissioning most hospital and community health services from the old Health Authorities.

This increased role for PCTs is intended to deliver improvements for patients by focusing on supporting frontline staff and empowering them to make decisions locally.

Primary Care Trusts are now the lead NHS organisations. They will assess need, plan and secure all health services, improve health in their localities, provide most community services and develop primary care services. NHS trusts will continue to provide most secondary care and specialist services in hospitals.

Once enacted, the National Health Service Reform and Health Care Professions Bill introduced in November 2001 will impose a legal duty on the Secretary of State to establish Primary Care Trusts across all of England.

PRIMARY CARE TRUSTS — THE STATUTORY FRAMEWORK

1. Primary Care Trusts are established by the Secretary of State with a view to:
 - (a) providing, or arranging for the provision of, hospital and community health services under Part I of the 1977 Act;
 - (b) exercising Health Authority functions in relation to the provision of general medical services under Part II of the Act, and
 - (c) providing services in accordance with arrangements made for the provision of personal (i.e., general) medical services under a pilot scheme.
2. Each Primary Care Trust serves the area specified in its establishment order, each area being wholly contained within the area of a Health Authority.
3. The trusts are corporate bodies with their own budget for local health care. Typically, an English trust is likely to serve a population of at least 100,000, and have a budget of around £60m or more.
4. A substantial number of PCT members must be GPs, local nurses and other health care professionals involved in providing services under the National Health Service Act. The Chairman and the lay members are, however, appointed by the Secretary of State.
5. Once a proposal to establish a Primary Care Trust has been selected or initiated by a Health Authority, it is the subject of a consultation conducted in accordance with regulations.
6. Trusts are subject to directions given by the Secretary of State. In particular, the Secretary of State may determine which functions may or may not be delegated to Primary Care Trusts, and the extent to which they may be delegated.
7. Subject to any directions of the Secretary of State, a PCT's particular functions are mainly conferred by directions of the local Health Authority, to which it is accountable. The Health Authority may also direct it as to the exercise of delegated functions, although it is not intended that they should seek to control detailed day-to-day operational matters.
8. Although the Health Act did not specify what services Primary Care Trusts will or will not commission, the intention was that responsibility for commissioning most hospital and community health services would be delegated to them.
9. In some cases, a Primary Care Trust may also provide hospital and community health services for their local population (in practice, usually community health services), a function currently performed by NHS trusts. In this respect, a Primary Care Trust is something of a 'hybrid' between a Health Authority and an NHS trust.

10. Progression from a commissioning-only trust to a commissioning-and-providing trust is subject to consultation and approval by the Secretary of State.
11. Although mainly concerned with the Part I system relating to hospital and community health services, Primary Care Trusts may exercise certain Health Authority functions relating to general medical services. Subject to regulations and directions, Health Authorities may direct them to exercise the authority's functions in relation to general medical services.
12. Functions relating to high security psychiatric services, and family health service functions other than general medical services, cannot be delegated to PCTs.
13. Primary Care Trusts are funded by Health Authorities under section 97C of the 1977 Act. They are subject to a set of financial duties similar to those for Health Authorities, and the same distinction is drawn between cash-limited and non-cash-limited funding.
14. The trusts have considerable flexibility when it comes to arranging for the performance of their functions. For example, it is possible for them to pool administrative support services such as IT, estate and payroll management with other NHS bodies.
15. Trusts must prepare and provide reports and information on their activities to the relevant Health Authority and the Secretary of State. This enables Health Authorities to monitor their performance. They must publicise their accounts, an annual report, any auditor's report given under section 8 of the Audit Commission Act 1998, and any other documents specified in regulations.

Functions

According to '*Shifting the Balance of Power*', a PCT's key functions include:

- Improving the health of the community through community development, service planning, health promotion, health education, commissioning, occupational health and performance management. PCTs will identify the health needs of their local populations, develop plans for health improvement, lead the development of the local health strategy, and deliver it by providing and commissioning services from primary care practitioners and NHS Trusts.
- Securing the provision of:
 - a) primary care, community health, mental health and acute secondary care services;
 - b) personal medical services including out-of-hours and walk-in centres;
 - c) medical, dental, pharmaceutical and optical services;
 - d) emergency ambulance and patient transport services;
 - e) the health contribution to child protection services;
 - f) all primary care development.
- Regulating the contracts of all family health services providers.
- Managing clinical performance in the PCT.
- Developing a coherent modern nursing service.
- Implementing population screening.

- Ensuring the involvement of patients, public, voluntary sector and local communities in plans.
- Integrating local health and social care through the use of recent legislation. Where the local agencies agree, care trusts 'will be important vehicles for modernising both social and health care, helping to ensure that integrated services are focused on the needs of patients and users'.

Funding

PCTs will control 75 per cent of total NHS funds by 2004. They will be directly funded by the Secretary of State, rather than by Health Authorities, and the funding arrangements mirror those by which the Secretary of State previously allocated monies to Health Authorities. Providing funds directly to PCTs is intended to help 'empower' frontline staff and patients in the planning, modernisation and delivery of services.

Block capital will be given directly to PCTs, using a national formula that measures the need for investment.

The Secretary of State may increase the allotments made to a Primary Care Trust if it has satisfied preset objectives over a defined period, or performed well against criteria relevant to their satisfactory performance of functions. These additional sums may be subject to conditions.

Designation as a Care Trust

The Health & Social Care Act 2001 provided for designating Primary Care Trusts *and* NHS trusts as care trusts, which are intended to integrate health and local authority services. In particular, care trusts will be able to commission and/or provide integrated services covering health, social services and other health-related local authority functions. A number of care trusts were established in April 2002.

The basic care trust framework is as follows:

- Care trusts are NHS bodies that combine a PCT(s) or NHS Trust(s) with local authority services. Their establishment is intended to help to ensure that health and local authority services are coordinated and integrated locally.
- Care trusts may be established either by dissolving an existing PCT or NHS trust or by amending their establishment order. More particularly, an existing PCT or NHS trust may be designated as a care trust where they have local authority health-related functions delegated to them by agreement.
- The two basic care trust models are therefore, firstly, incorporating social care within (specialist mental health) NHS trusts; and, secondly, PCTs taking on mental health and social care (the 'PCT+ model'). Here, a PCT would take on certain specialist mental health and social care services and commission the remainder.

- Applications to the Secretary of State for care trust status are made jointly by the NHS bodies and local authorities involved. The proposal must have been subject to local consultation; and the Secretary of State must be of the opinion that care trust status is likely to promote the effective exercise by the trust of any delegated local authority health-related functions alongside the trust's existing NHS functions. This reflects the main aim that such a trust will improve services through effective integration of NHS and local authority services.
- Designation as a care trust will lead to a change in governance arrangements, so that local authority interests are duly represented within the governance structures of the trust. According to the regulations, the non-officer members of a PCT designated as a care trust must include at least one member of the relevant local authority (appointed by the Secretary of State following nomination by the relevant local authority), and at least one person who is representative of users of services of the trust.
- Where an NHS body is to exercise social services functions as a care trust, it must act in accordance with directions and guidance from the Secretary of State in relation to its acquired social services functions.
- It is possible for a care trust to be imposed by the Secretary of State following failures in joint working.

Some of the possible advantages and disadvantages of care trusts are summarised in the following table:

CARE TRUSTS	
Possible advantages	
■	Integration of the purchase and provision of health and social care at every level (no gaps, delays, duplication or boundary disputes; improved care integration and communications).
■	Better crisis management (multidisciplinary intervention and crisis teams; hospital at home; joint management of emergency admissions; shorter hospital stays, less bed blocking).
■	Financial advantages (cost effectiveness, removing perverse incentives across health and social care).
■	Opportunity to re-organise badly managed services.
Possible problems	
■	Less partnership (care trusts are NHS bodies, and care trusts are a type of takeover, not a true partnership)
■	Loss of social care aims (because care trusts are NHS bodies, healthcare and medical/clinical model will be dominant, and local authority services and the social care model become an adjunct to health).
■	Disinvestment (most social services authorities spend above SSA, and this priority might not be maintained by local government in care trusts).
■	Conflict (inter-professional rivalry and stereotyping, resentment, suspicion, uneasiness).

- Complexity (harmonizing 'best value' and 'value for money' duties; setting eligibility criteria; managing charging for services; different accountability and scrutiny schemes; harmonizing the terms and conditions of health and social care staff).
- Loss of accountability (the NHS is not as accountable as local government).
- Less effective co-ordination of social services and other local authority services, such as housing and education (at present, social services is the bridge between health services and wide local government services).
- Defensive medicine due to litigation spilling over into defensive social care.

Requirements

- A coherent strategy with regard to health and social care accountability systems, internal governance and professional accountability.
- Good attitudes, e.g. with regard to cultural differences between the medical and the social model, and the need to change behaviour and challenge stereotypes.
- One set of values, not two (both services working together in the same buildings; joint needs assessment and service commissioning; shared ownership; joint inspections; equal consultation).
- Governance and management arrangements that enable local councils to maintain democratic accountability.
- Power sharing and working arrangements that are joined at the frontline, and not just senior management level.
- Information sharing arrangements.
- Clear measurements of success.

B. THE PROVISION OF SOCIAL CARE

Local Authorities are responsible for performing community care functions and other social services functions, such as housing and education.

The gross expenditure of English local authorities on personal social services in 1998–99 amounted to £10,847m. This included £564m on mental health services and £1,495m on learning disability services. About half of the gross expenditure was on provision for older persons (a quarter of which was recouped through sales, fees and charges), and nearly a quarter on provision for children. Central and strategic costs (including regulation and inspection) accounted for only 1% of gross expenditure.

According to Department of Health data, the number of adults in staffed residential care being supported by English local authorities increased from 144,312 on 31 March 1994 to 249,438 on 31 March 1998. Of the latter:

- 202,722 were people aged 65 or over.
- 9,277 were categorised as people with mental health problems (compared with 4,432 on 31 March 1994), and 26,029 as people with learning disabilities (1994: 17,648).
- 54,611 were in local authority staffed residential care; 121,923 in independent residential care; and the remaining 72,904 in independent nursing care.

Social services functions

A local authority's 'social services functions' include providing residential accommodation for adults suffering from mental disorder; promoting the welfare of adults who suffer from mental disorder; temporarily protecting the property of persons in hospital or Part III accommodation; providing facilities for enabling disabled persons to be employed or work under special conditions; promoting the welfare of old people; providing certain welfare services; preparing plans for community care services; assessing people's needs for community care service; and various functions under the Mental Health Act 1983.

Exercise of social services functions

The Local Authority Social Services Act 1970 imposed a requirement on local authorities to establish a social services committee to deal with matters relating to the discharge by it of its statutory social services functions. However, the Local Government Act 2000 provides that this requirement no longer applies where the authority adopts one of the forms of local authority executive provided for by that Act.

Local authority executives

The Local Government Act 2000 received Royal Assent on 28 July 2000. The Act provides for local authority executives and executive arrangements. Section 11 specifies three particular forms of executive: A directly-elected mayor who appoints between two and 10 councillors to the executive ('a mayor and cabinet executive'). An executive leader, elected by the full council, plus between two and 10 councillors appointed by the leader or the council ('a leader and cabinet executive'). A directly-elected mayor, with an officer of the authority appointed by the council as a council manager ('a mayor and council manager executive').

Overview and scrutiny committees

Under executive arrangements, social services and other council functions are no longer carried out by committees that reflect the political balance of the council, and new ways of scrutinising the conduct of council business are necessary.

Section 21 of the Local Government Act 2000 requires authorities operating executive arrangements to set up overview and scrutiny committees in order to hold the executive to account. Any member of such a committee may ensure that any relevant matter is put on the agenda and discussed at its meetings.

Committees may make reports and recommendations, either to the executive or to the authority, on any aspect of council business. They may also make reports and recommendations on other matters which affect the authority's area or its inhabitants.

An overview and scrutiny committee may require officers and members of the executive to appear before it, and may invite any other person to appear before it. It may review and scrutinise executive decisions, and recommend that they are reconsidered or arrange for the authority to review them.

A mixed economy of care

The National Health Service & Community Care Act 1990 fundamentally changed the way in which social care is provided to people suffering from mental disorder.

The underlying philosophy of the legislation was to separate out the functions of purchasing and providing such care, so as to create an 'internal market' in the health service and a 'mixed economy of care' in relation to social services.

Just as the role of Health Authorities became one of purchasing health services provided by NHS trusts, so local authorities were developed as 'enabling authorities' and 'commissioning agencies', seeking out and purchasing community care services from a range of public and non-public providers.

The enabling and commissioning roles of a local authority involve it:

- identifying the need for care among the population it serves;
- planning how best to meet those needs;
- setting an overall strategy in terms of priorities and targets;
- seeking out, and purchasing, the required services from a range of providers in the voluntary, private and public sectors (that is developing a mixed economy of care); and
- monitoring the quality of the services which it has purchased.

The general position today is that any community care services that can be provided by a local authority may also be provided by an agency from the independent sector.

Community care functions

The term 'community care services' is defined in section 46 of the National Health and Community Care Act 1990. Community care services are services that a local authority may provide or arrange under:

- Part 3 of the National Assistance Act 1948,
- Section 45 of the Health Services and Public Health Act (promotion by local authorities of the welfare of old people),
- Section 21 of and Schedule 8 to the National Health Service Act 1977; and
- Section 117 of the Mental Health Act 1983 (after-care).

The practical importance of the definition is that local Authorities have a duty, under section 47 of the 1990 Act, to assess a person's need for community care services. This is undertaken through what is called the care management process.

The care management process begins with a local authority 'care manager' undertaking an assessment of an individual's need for services. If the person is assessed to need a community care service, a care plan is then drawn up. This plan should ensure, as far as possible, that normal living is preserved or restored, primarily by providing the services within the user's home, including (where necessary) day and domiciliary care, respite care, and the provision of disability equipment and adaptations to the home. Care managers therefore act as brokers for services across the statutory and independent sectors.

Partnership arrangements

The Health Act 1999 extended the duty of co-operation between NHS bodies and local authorities in England and Wales. In addition, section 2 of the Local Government Act 1999 empowers local authorities to take any steps which they consider are likely to promote or improve the economic, social or environmental well-being of their local community. This power enables them to work in partnership with other bodies, for example by assisting other statutory bodies to discharge their functions, or by exercising functions on their behalf.

Under the new NHS partnership legislation, NHS trusts may provide social care, and likewise local authorities may provide health care. Furthermore, health and local authorities may pool budgets or nominate a lead commissioner for specific client groups. These measures are intended to allow the authorities to agree jointly who is best placed to carry out their functions, and how resources may be used more efficiently.

Where NHS services or social services are failing, section 46 enables the Secretary of State to direct an NHS body and local authority to enter into partnership arrangements and/or pooled funding arrangements. The exercise of the power is limited to situations where a local authority or NHS body is failing to deliver its functions adequately, and the Secretary of State is of the opinion that a delegation or pooled fund arrangement would be likely to improve the delivery of the failing function.

'Best value'

The Local Government Act 1999 repealed those laws that required authorities to submit activities to compulsory competitive tendering; and imposed a new statutory duty on them to arrange for delivering 'best value' in the way in which their functions are performed. 'Best value' means securing continuous improvement in the exercise of the authority's functions, having regard to economy, efficiency and effectiveness.

The 1999 Act empowers the Secretary of State to prescribe performance indicators against which best value authorities will be measured; and to set national standards which authorities must meet in order to discharge the duty. The Audit Commission may carry out inspections aimed at assessing the degree to which authorities are complying with the requirements of the best value legal framework; and the Secretary of State is given a wide range of intervention powers in response to failures.

Under the Act, authorities were required to carry out an initial assessment of whether to perform functions they may perform, how, by whom, and to what standard. They are also required to prepare and publish annual Local Performance Plans (LPPs). These plans are scrutinised by auditors, who must comply with any code of practice produced by the Audit Commission. The authority must publish the auditor's report. If it contains recommendations about follow-up action, the authority is required to publish a statement of the action it proposes to take, and its timetable for doing so.

C. INDEPENDENT HEALTHCARE

In accordance with the NHS plan, the NHS has agreed a new national framework with the Independent Healthcare Association that enables NHS patients to be treated free in the private and voluntary health care sector. According to this 'concordat', there should be no organisational or ideological barriers to the delivery of high quality healthcare free at the point of delivery to those who need it, when they need it.

Prior to 1 April 2002, independent mental health establishments were regulated as mental nursing homes (including those larger establishments often referred to as 'private hospitals'). Statistical data published by the Department of Health shows that:

- The number of registered mental nursing homes rose by 8% to 1073 during the year to 31 March 2000; and the number of beds in such homes by 4% to 31,828.
- 28,709 of these beds were intended for mental health use, of which only 6392 were occupied by people aged 64 or under.
- 182 of the 1073 registered mental nursing homes were registered to receive detained patients under the 1983 Act (17%), and these homes provided 1,465 beds.
- The number of formal admissions to mental nursing homes under the 1983 Act increased from 400 in 1990–91 to 1400 in 2000–01. 1200, or 86%, of these admissions were under Part II (compared with 95% for NHS hospitals).
- At 31 March 2001, 1,700 of the 13,800 patients detained in hospital under the 1983 Act were in private mental nursing homes (one in eight).
- Mental nursing homes now receive the majority of people detained under the Act on the grounds of mental impairment or severe mental impairment.
- 96 of the 1073 registered mental nursing homes had a resident medical practitioner, and 96 a registered pharmacy.
- 51,200 qualified whole time equivalent nursing staff were working in all private nursing homes, hospitals and clinics, of whom 69% were registered general nurses, 15% registered nurses, and 12% registered mental nurses.

Care Standards Act 2000

The Care Standards Act 2000 repealed the Registered Homes Act 1984. The Act, which came into force on 1 April 2002, defines independent healthcare services in three categories: independent hospitals; independent clinics; and independent medical agencies (agencies that provide doctors to visit private patients). Under the new scheme, some existing 'mental nursing homes' constitute 'independent hospitals' and others 'care homes'.

Independent hospitals

Section 2(3) of the Care Standards Act defines an independent hospital as any establishment which has *as its main purpose* the provision of psychiatric or medical treatment for illness or mental disorder (including palliative care), or which provides a 'listed service'; and any other establishment that provides treatment for people liable to be detained under the Mental Health Act 1983. The definition of 'people liable to be detained' does not include those on section 17 leave.

'Listed services' are services which, due to the potential risk to the patient, can only be provided by an independent hospital, and regulated accordingly. The listed services include medical treatment under anaesthesia or sedation.

The definition of an independent hospital includes clinics that treat people for alcohol and drug misuse and eating disorders if their main purpose is to provide psychiatric treatment for illness or mental disorder. According to guidelines, an establishment that provides care for elderly people with dementia will be a care home, as its main purpose is not the provision of mental health treatment.

Care homes

A 'care home' is defined, by section 3, as a home that provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol. The definition is intended to include residential care homes and nursing homes as defined in the 1984 Act. The Commission will be able to impose conditions on care homes as to the categories of person they can accommodate.

Residential care homes run by NHS bodies must be registered under this definition, as the provision of residential homes is not a core NHS function. Local authority homes provided under Part III of the National Assistance Act 1948 must also register.

'Personal care' in this context includes assistance with bathing, dressing and eating for people who are unable to do these things without help. This means that an establishment is not 'a care home' unless this type of assistance is provided where required.

Homes that provide personal care and accommodation for disabled children are treated as children's homes.

Some establishments must be separately registered, both as an independent hospital and a care home. This is because an establishment may have a number of premises on the same grounds, and in one provide psychiatric treatment for people with eating disorders and on another provide care to elderly people with dementia. These establishments must be registered separately and regulated to different standards, to ensure that the care provided meets the needs of the patients.

Independent clinics

In essence, an independent clinic is an establishment other than a hospital within which medical practitioners provide services to private patients only. In 1999, it was estimated that there were 95 psychiatric clinics, providing 468 beds. However, it is thought that as many as 3,000 specialist doctors may operate significant private practices, many from home.

Public-private partnerships

As amended, section 96C of the National Health Service Act 1977 enables the Secretary of State to participate in public-private partnerships with companies that provide facilities or services to persons or bodies carrying out NHS functions. The new powers can be delegated to Health Authorities, and through them to Primary Care Trusts and Special Health Authorities. The intended first use of this new power is the establishment of NHS LIFT (NHS Local Improvement Finance Trust), which invests in primary care premises.

Private Finance Initiatives

Private Finance Initiatives (PFI) involve the use of private finance in capital projects, particularly in relation to the design, construction and operation of buildings and support services. Such initiatives are the most common form of financing new capital projects in the NHS, and the majority of schemes relate to the provision of hospital facilities.

Major PFI schemes are usually on a 'design, build, finance and operate' (DBFO) basis, where the contractor takes on a facilities management role for the duration of the contract. These contracts generally range from 25 to 35 years.

The estimated total capital value of major schemes (those with individual capital values of over £25 million) closed by 31 March 2000 was nearly £1.4 billion.

During 2000–2001, a further 29 major schemes with a capital value of over £3.1 billion were submitted for assessment to the Capital Prioritisation Advisory Group. In February 2001, Ministers approved all 29 schemes.

Although no major PFI schemes were operational by 31 March 2000, four became operational during 2000–2001.

D. MAINTAINING QUALITY STANDARDS

The attention of public bodies that oversee service standards focuses on one of two things:

- Quality standards (setting, monitoring and enforcing quality standards; patient safety; implementing service reforms designed to improve quality).
- Legal standards (including the maintenance of ethical standards that may not be legally enforceable).

As one would expect, the vast majority of the public bodies that come under the umbrella of the Department of Health exist in order to ensure or improve the safety and quality of health and social care.

SETTING QUALITY STANDARDS

In December 1998, the Government promised to modernise mental health services by providing safe, sound and supportive services ('*Modernising Mental Health Services*', Department of Health, December 1998).

Before 1999, there was no statutory duty on NHS bodies in respect of the quality of care provided to patients (although they owed a duty at common law to exercise reasonable care and skill when providing treatment and other services). Section 18 of the Health Act 1999 changed this, by imposing a 'duty of quality' on Health Authorities, Primary Care Trusts and NHS trusts.

According to the NHS Plan, the Department of Health will set national standards, in conjunction with leading clinicians, managers and staff. Some of the main standards set for mental health services are listed in the following table.

QUALITY STANDARDS FOR MENTAL HEALTH SERVICES		
Universal standards		
The national service framework for mental health		
The care programme approach		
NHS standards	Local authority standards	Local Authority & Independent care standards
Guidance published by the National Institute for Clinical Excellence (NICE)	National inspection standards (Social Services Inspectorate)	National minimum standards for care homes & independent healthcare
Patient's Charter	Social services performance assessment framework	General Social Care Council Codes of Practice
Performance assessment framework	Best value duty	Guidance published by the Social Care Institute for Excellence
Value for money duty		

National Service Framework (November 1999)

National Service Frameworks are detailed documents setting out the standards expected of the NHS in meeting the needs of specific patient groups. The framework for mental health sets seven key standards in five areas:

- | | |
|-----------------|--|
| Standard 1 | ● Mental health promotion |
| Standards 2 & 3 | ● Primary care and access to services |
| Standards 4 & 5 | ● Effective services for people with severe mental illness |
| Standard 6 | ● Caring about carers |
| Standard 7 | ● Preventing suicide |

Each standard is supported by a rationale, by a narrative that addresses service models, and by an indication of performance assessment methods. Each standard indicates the lead organisation and key partners. Performance is assessed at a national level by measures that include factors such as the national psychiatric morbidity survey; reduction in suicide rates, etc. The outcome indicators for cases of severe mental illness include the prevalence of severe illness; the proportion of CPA plans signed by service users; the incidence of serious physical injury; and the prevalence of side effects from anti-psychotics.

Care programme approach

The requirements of the care programme approach form part of the national service framework for mental health. 'Modernising the care programme approach', published in October 1999, set out important changes to the approach, which took account of available evidence and experience. Some of the key developments were the integration of CPA and care management; the appointment of lead officers within each trust and local social services authority; the introduction of two CPA levels (standard and enhanced); the removal of the previous requirement to maintain a supervision register; and the use of the term 'care co-ordinator' in place of 'key worker'. Adherence to the care programme approach is one of the guiding principles set out in the Code of Practice on the Mental Health Act.

National Institute for Clinical Excellence

The National Institute for Clinical Excellence was established by the Secretary of State as a Special Health Authority on 1 April 1999. It produces formal advice on the clinical and cost effectiveness of new and existing technologies, including drugs, diagnostic tests and surgical procedures, and guidance on how clinicians can compare their current standards with best current practice (clinical audit). It sets clinical guidelines and a clinical audit framework. The institute has an executive board consisting of four executive members (Chief Executive, Director of Resources and Planning, Communications Director and Clinical Director) and seven non-executive members. NICE completed 16 technology appraisals between 1 December 1999 and 31 December 2000, and it published a patient-friendly version of each appraisal.

National Performance Assessment Framework

The National Performance Assessment Framework sets out various indicators and standards by which NHS Trusts are to be measured, for example waiting times for patients and the outcomes of specific medical interventions.

Social Services Inspectorate standards

The SSI sets standards for each of its national inspections, and evaluates services against these standards. There are currently 29 standards.

Minimum care standards

The Care Standards Act 2000 authorises the Secretary of State to publish national minimum standards for care homes and independent healthcare providers, with which they are expected to comply. The National Care Standards Commission (see below) may give advice about changes to the standards, with a view to securing improvement in the quality of services.

General Social Care Council Codes

Although approximately one million people work in social care, the large majority have no recognised qualifications or training, and there are no nationally agreed standards of practice or conduct. Section 62 of the Care Standards Act 2000 now requires the new General Social Care Council to produce codes of good practice for social care workers and the employers of such staff.

Social Care Institute for Excellence (SCIE)

A Social Care Institute for Excellence was established at the end of 2001, to develop and promote a knowledge base of what works in social care. It is intended to play an important role in creating a culture in social services that prioritises quality, evidence based knowledge and a commitment to continuous improvement. In developing its knowledge base, it will draw on the views and experience of service users, research evidence, inspection findings and the experience of managers and practitioners.

The Patients' Charter

The Patient's Charter sets out the rights and responsibilities of patients, including the standards that they can expect from different levels of the Health Service.

Professional codes and standards

Professional bodies issue codes of practice and regulations, setting standards of practice and conduct. Revalidation is a process being introduced by the General Medical Council. Under it, all doctors will have to prove their continuing fitness to practice on a regular basis.

DELIVERING QUALITY STANDARDS

The way in which quality standards are monitored and delivered varies by sector. Some of the main mechanisms are summarized in the following table.

ENSURING THE QUALITY OF MENTAL HEALTH SERVICES	
Method	Mechanisms
Supporting services	<ul style="list-style-type: none"> • Modernisation Agency
Establishing clinical and service networks	<ul style="list-style-type: none"> • National Institute for Mental Health in England
Regulating professional practice	<ul style="list-style-type: none"> • A Council for the Regulation of Health Care Professionals • General Social Care Council • Protection of vulnerable adults scheme
Reviewing competence to practice	<ul style="list-style-type: none"> • The National Clinical Assessment Authority
Improving patient safety	<ul style="list-style-type: none"> • The National Patient Safety Agency
Public and patient involvement	<ul style="list-style-type: none"> • A statutory duty to involve patients and the public. • Local authority overview and scrutiny committees. • An independent reconfiguration panel. • An independent complaints advocacy service. • NHS complaints procedures. Reinforced by: • Health Service Commissioner • Parliamentary Commissioner • Social services complaints procedures, e.g. re community care services. Reinforced by: • Local Authority Commissioner

Clinical governance	● Patients Forums.
External monitoring — NHS	● A Commission for Patient and Public Involvement in Health
— Care homes, independent healthcare	● Patient and user surveys.
— Social services	● Clinical governance guidance.
— Value, efficiency	● The Commission for Health Improvement
Intervention	● National Care Standards Commission
	● Social Services Inspectorate
	● Audit Commission
	● Inquiry and intervention powers (Secretary of State)

Brief notes follow on those organizations created by the present Government since it came to power in 1997. It will be seen that four public bodies are now responsible for inspecting health and social care authorities and agencies, and for reviewing the quality of their services: The Commission for Health Improvement; The National Care Standards Commission; The Social Services Inspectorate (which is part of the Department of Health); and The Audit Commission.

Modernisation Agency

The Modernisation Agency was set up to support the improvement of services. It aims to help professionals and managers redesign and improve local health services around the needs and convenience of patients. Various organisations make up the agency. They include the Social Care Institute for Excellence and the NHS Clinical Governance Support Team (CGST). The new National Institute for Mental Health in England is located within it.

National Institute for Mental Health in England (NIMHE)

A National Institute for Mental Health was established in Autumn 2001, led by Professor Louis Appleby, the National Director for Mental Health. The overall aim of the Institute is to drive forward the implementation of the National Service Framework for Mental Health and the changes for mental health services set out in the NHS Plan. The Institute will initiate the development of regional clinical and service development networks. These will bring together best current practice with new developments in mental health, so as to ensure that high quality care is consistently provided. The Institute's first task will be to develop a national research plan, and to set up a network of leading institutions to work collaboratively.

Professional regulatory bodies

Parliament has created statutory frameworks for many healthcare professions, within which the professions regulate themselves. Each of the groups has its own regulatory body operating within its own legal framework:

Doctors	General Medical Council	Medical Act 1983
Dentists	General Dental Council	Dentists Act 1984
Nurses, midwives and health visitors	Nursing and Midwifery Council	Nurses, Midwives and Health Visitors Act 1997/Health Act 1999
Opticians	General Optical Council	Opticians Act 1989
Pharmacists	Royal Pharmaceutical Society of Great Britain	Pharmacy Act 1954; Medicines Act 1968
Osteopaths	General Osteopaths Council	Osteopaths Act 1993
Chiropractors	General Chiropractic Council	Chiropractors Act 1994
Professions supplementary to medicine (12)	The Health Professions Council	Professions Supplementary to Medicine Act 1960/Health Act 1999

Council for the Regulation of Health Care Professionals

Clause 23 of the National Health Service Reform and Health Care Professions Bill provides for the establishment of a Council for the Regulation of Health Care Professionals. The Bill gives the Council the functions of promoting the interests of patients and the public in the way that statutory regulatory bodies carry out their work, and promoting co-operation between them. The Council is to be a non-ministerial government department financed out of money provided by Parliament, and paid to it by the Secretary of State.

General Social Care Council

Section 70 of the Care Standards Act 2000 abolished CCETSW in relation to England and Wales, and established a General Social Care Council. The Council is a non-departmental public body sponsored by the Department of Health. It will operate according to rules approved by the Secretary of State.

Section 56 of the 2000 Act provides for the Council to establish and maintain a register of social care workers. Section 61 enables the title of 'social worker' to be protected, by making it an offence to describe oneself as a social worker, with intent to deceive, if not registered as a social worker. Sections 63 to 66 of the Act set out the new Council's functions with regard to the education and training of social workers. The Council is given wide powers to make rules about the approval of courses, with the intention of ensuring the consistency and quality of the education to be provided at pre- and post-qualifying levels.

Protection of vulnerable adults scheme

Section 81 of the Act places a duty on the Secretary of State to keep a list of care workers who are considered unsuitable to work with vulnerable adults. Providers of care services to vulnerable adults are required to refer individuals for inclusion in the list in certain circumstances. In addition, the Secretary of State may consider for inclusion individuals named in the findings of certain inquiries. The provisions only apply to healthcare establishments where individuals are employed in prescribed services (for example, wards for older people).

National Clinical Assessment Authority (NCAA)

'Building a Safer NHS for Patients' (Department of Health, April 2001) set out the Government's plans for patient safety in the context of the NHS quality programme. Where there is evidence of poor clinical performance, and the problem cannot be evaluated or resolved locally, or is particularly serious, the medical practitioner concerned will be referred to the new National Clinical Assessment Authority. This authority will make a thorough assessment, and give advice to the trust or health authority. Educational and training solutions will be used where possible, but serious problems will be referred to the General Medical Council. The NCAA will notify the Commission for Health Improvement if there may be wider service problems that need to be investigated.

The National Patient Safety Agency

The new National Patient Safety Agency will collect and analyse information on adverse events from local NHS organizations and staff, patients and carers; assimilate other safety-related information from a variety of existing reporting systems and other sources in England and abroad; learn lessons and ensure that they are fed back into practice, service organisation and delivery; produce solutions to identified risks, to prevent harm; and specify national goals and establish mechanisms to track progress.

In future, there will be only two ways of responding to a failure of a whole service, a seriously dysfunctional service, or major systems weaknesses: an independent inquiry commissioned by the Department of Health or an investigation by the Commission for Health Improvement (the approach to be agreed between the Department and the Commission in each case). Inquiries into mental health services will be brought within this integrated approach. There will be no ad hoc external investigations or inquiries commissioned by trusts or health authorities; nor will comprehensive internal inquiries be carried out. Internal reviews will be limited to scoping investigations designed to inform a decision as to whether an independent investigation is required.

Risks to patients that arise from the poor performance of an individual practitioner will be dealt with by the new National Clinical Assessment Authority. Patient complaints will be dealt with under NHS complaints procedures, and staff concerns about care standards will be addressed by the new adverse event reporting system, or as part of clinical governance.

Public and patient involvement

Section 11 of the Health & Social Care Act 2001 imposes on each Health Authority, Primary Care Trust and NHS trust a new statutory duty to make arrangements for involving patients and the public in their planning and decision making processes, insofar as they affect the operation of the

health services for which the body is responsible. In relation to Health Authorities, this covers both hospital and community health services and the family health services provided in their area.

Local authority overview and scrutiny committees

Sections 7 to 10 of the 2001 Act provide for local authority overview and scrutiny committees to scrutinise the NHS, and to represent local views as to the development of health services.

The Local Government Act 2000 gave these committees power to scrutinise local authority social services functions. The 2001 Act then conferred on them the function of reviewing and scrutinising health service matters, and making reports and recommendations to NHS bodies about such matters. In this respect, they can also oversee and scrutinise social care services provided or commissioned by an NHS body that exercises local authority functions (under partnership arrangements).

Health Authorities must consult the local committee on major service changes, and the Chief Executives of local NHS bodies are required to attend overview and scrutiny committee meetings at least twice a year.

Independent Reconfiguration Panel

The functions of overview and scrutiny committees include referring contested proposals for major service changes to the Secretary of State on the grounds of process and merit. A new Independent Reconfiguration Panel will advise the Secretary of State on proposals referred to him in this way; and its membership will include clinicians, patient representatives and NHS managers.

Independent complaints advocacy service

Section 12 of Health & Social Care Act 2001 imposes a duty on the Secretary of State to arrange independent advocacy services for people who wish to complain about the service that they, or someone whom they care for, has received from the NHS. The arrangements for discharging this duty centre on new, non-statutory, Patient Advocacy and Liaison Services (PALS). These trust-based services will be situated in or near the main reception areas of hospitals, and 'act as a welcoming point for patients and carers.' They will provide information, help to resolve problems and difficulties, and advise patients on how to access independent advocacy to support complaints.

Patients' Forums

The National Health Service Reform and Health Care Professions Bill introduced in November 2001 provides for the establishment of Patients' Forums. Their membership is to be drawn from voluntary sector organisations representing patients and/or carers and from individual patients.

Clause 15 of the Bill requires the Secretary of State to establish a Patients' Forum for each Primary Care Trust and NHS trust in England, and sets out their functions. These include monitoring and reviewing the services for which the trust is responsible, obtaining and reporting to the trust the views of patients and their carers, and making available to patients advice and information about the trust's services. Where a trust exercises local authority functions, for example social care services, the forum will also monitor these services.

In accordance with regulations, the forum may assume responsibility for arranging or providing services to assist patients. This could include Patient Advocacy and Liaison Services (PALS), where the trust PALS service is not performing satisfactorily.

Clause 16 of the Bill gives the Secretary of State power to make regulations requiring Strategic Health Authorities, trusts or providers of family health services (e.g. GPs and pharmacists) to allow authorised members of Patients' Forums to inspect premises owned or controlled by them.

Commission for Patient and Public Involvement in Health

The National Health Service Reform and Health Care Professions Bill, introduced in November 2001, also establishes a new independent corporate body called The Commission for Patient and Public Involvement in Health.

The Secretary of State may direct the Commission to perform his duty of making arrangements for independent advocacy for people wishing to complain against the NHS. This aside, the Commission's other functions are to:

- advise the Secretary of State about the arrangements that are in place across England for the involvement and consultation of patients and the public in matters relating to the NHS.
- promote public involvement in decisions and consultations on matters affecting the health of the population. It will be able to do this at a local and national level.
- advise the Secretary of State on arrangements for independent advocacy services.
- report to the Secretary of State the views of locally based patient and public involvement bodies (including Patients' Forums) on such arrangements, e.g. as to how effectively they are operating.
- facilitate the co-ordination of Patients' Forums and to provide assistance to them. It is intended that the Commission's local arrangements will provide them with administrative support.
- give advice and assistance to providers of independent advocacy services. This could be in the form of guidance or training.
- set quality standards for the activities of Patients' Forums and the provision of independent advocacy services. It will also monitor how effectively these standards are met.
- make reports of the public's views on matters affecting their health to any local body that has an influence over the health of the public; in particular, Local Authority Overview and Scrutiny Committees.

Clinical Governance

The Health Act 1999 imposed a statutory duty of quality on Health Authorities, Primary Care Trusts and NHS trusts; and these bodies are now required to have in place arrangements for monitoring and improving the quality of the health care they provide. Clinical governance is the name given to these arrangements.

The first clinical governance guidance was published in March 1999, under Health Service Circular HSC 1999/065.

The main components of clinical governance are clear lines of responsibility and accountability for the overall quality of clinical care; a comprehensive programme of quality improvement (including

clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development); clear policies aimed at managing risk; and procedures for all professional groups to identify and remedy poor performance.

Commission for Health Improvement

The Health Act 1999 established new arrangements for improving the quality of the care provided to NHS patients. In particular, it imposed a statutory duty of quality on health service bodies, and established a commission to monitor and help improve quality.

The Commission for Health Improvement is responsible for monitoring the quality of care for which NHS bodies are responsible through a variety of reviews and investigations. It carries out regular inspections every three to four years, and has the power to look at adverse incidents.

The Commission's establishment was accompanied by the dissolution of the Clinical Standards Advisory Group (CSAG). Since 1990, its function had been to advise on standards of clinical care in the NHS, and on access to, and the availability of, services to NHS patients.

Section 20(1) of the 1999 Act, reproduced below, sets out the Commission's core functions.

CORE FUNCTIONS OF THE COMMISSION FOR HEALTH IMPROVEMENT

Health Act 1999

20.-(1) The Commission has the following functions:

- (a) providing advice or information with respect to arrangements by Primary Care Trusts or NHS trusts for the purpose of monitoring and improving the quality of health care for which they have responsibility,
- (b) conducting reviews of, and making reports on, arrangements by Primary Care Trusts or NHS trusts for the purpose of monitoring and improving the quality of health care for which they have responsibility,
- (c) carrying out investigations into, and making reports on, the management, provision or quality of health care for which Health Authorities, Primary Care Trusts or NHS trusts have responsibility,
- (d) conducting reviews of, and making reports on, the management, provision or quality of, or access to or availability of, particular types of health care for which NHS bodies or service providers have responsibility, and
- (e) such functions as may be prescribed relating to the management, provision or quality of, or access to or availability of, health care for which prescribed NHS bodies or prescribed service providers have responsibility.

It is the duty of the Commission to carry out its functions effectively, efficiently and economically; and the Secretary of State may issue directions to the Commission as to the exercise of its functions.

Additional functions imposed by regulations

The Commission for Health Improvement (Functions) Regulations 2000 (S.I. 2000 No. 662) came into force on 1 April 2000. Clause 2, which is reproduced below, sets out various additional functions which the Commission is to perform.

ADDITIONAL FUNCTIONS PRESCRIBED BY REGULATIONS
The Commission for Health Improvement (Functions) Regulations 2000
(S.I. 2000 No. 662)

- 2.-(1) providing advice or information with respect to the arrangements by Health Authorities, Special Health Authorities or service providers for the purpose of monitoring and improving the quality of health care for which they have responsibility;
- providing advice or information with respect to the arrangements by Primary Care Trusts for the purpose of monitoring and improving the quality of health care provided by their relevant service providers;
- conducting reviews of, and making reports on, arrangements by Health Authorities, or Special Health Authorities to which the duty in section 18 of the Act has been extended, for the purpose of monitoring and improving the quality of health care for which they have responsibility;
- conducting reviews of, and making reports on, arrangements by Primary Care Trusts for the purpose of monitoring and improving the quality of health care provided by their relevant service providers;
- carrying out investigations into, and making reports on, the management, provision or quality of health care for which Special Health Authorities have responsibility;
- (with the Secretary of State's consent) providing advice with respect to the establishment and conduct of particular or proposed health service inquiries, such advice to take into account any guidance relating to health service inquiries given to NHS bodies by the Secretary of State.
- 4.-(1) providing advice or information on clinical governance arrangements to the Secretary of State, NHS bodies, and service providers (taking into account any guidance relating to clinical governance arrangements given by the Secretary of State, the National Institute for Clinical Excellence, or a body responsible for the regulation of a health care profession)

Powers

The Commission possesses extensive powers in connection with the performance of its statutory functions. The statutory authority for these powers derives from section 23 of the 1999 Act.

POWERS OF THE COMMISSION FOR HEALTH IMPROVEMENT
Health Act 1999, s.23

Section 23(1) of the 1999 Act provides that regulations may:

- confer on persons authorised by the Commission a right to enter premises owned or controlled by a health authority, PCT or NHS trust, in order that they may inspect the premises or inspect and take copies of documents (including electronic documents/information);
- require the production of documents, information to persons authorised by the Commission, and require relevant persons to make reports and/or to provide an explanation to the Commission in relation to matters within its remit.

Restrictions on the Commission's powers

The regulations may not authorise the disclosure of information that another Act states may not be disclosed, unless the other Act only prohibits disclosure because the information is capable of identifying an individual, in which case the regulations may authorise its disclosure in an anonymised form.

Furthermore, the regulations may only authorise the disclosure of information in health records which relate to and identify a living individual, or other information subject to a duty of confidence, if:

- the information is disclosed in an anonymised form; or
- the individual consents to the information being disclosed; or
- the individual cannot be traced despite the taking of all reasonable steps; or
- where the Commission is carrying out an investigation into, or reporting on, the management, provision or quality of health care by a health service body [under section 23(1)(c)], it is impracticable to disclose the information in an anonymised form; the Commission considers that there is a serious risk to the health or safety of patients arising out of the matters under investigation; and the risk and urgency of the situation are such that the Commission considers that the information should be disclosed without the individual's consent.

Such powers have been conferred by regulations on the Commission and persons authorised by it. See, The Commission for Health Improvement (Functions) Regulations 2000 (S.I. 2000 No. 662).

Sanctions

It is a criminal offence to obstruct a person authorised by the Commission who seeks to enter NHS premises. It is also an offence to fail to comply with a lawful request for documents or information or a request to provide an explanation made under the regulations under this section.

Future Developments

In April 2002, the Secretary of State for Health announced the Government's intention to establish a new Commission for Healthcare Audit and Inspection (CHAI). This new 'super-commission' will take over the work of the Commission for Health Improvement, the Audit Commission's work on value for money (see below), and the National Care Standards Commission's remit to inspect private hospitals (see below). It will be responsible for inspecting NHS hospitals, the Government's star rating system, the imposition of special measures for failing organisations, the licensing of private hospitals, the conduct of NHS value for money audits, the independent scrutiny of patient complaints, and (it seems) certain legal functions of a kind similar to those presently performed by the Mental Health Act Commission. New legislation will be required, and it is unlikely that the new body will be operational before 2004.

A second new commission, the Commission for Social Care Inspection, will inherit the National Care Standard Commission's care homes work, as well as the Social Services Inspectorate's remit to inspect and publish star rating for social services departments.

National Care Standards Commission

The Care Standards Act 2000 established a new regulatory system for the private and voluntary health care sector. Under this scheme, the National Care Standards Commission is established as the registration authority for England. The Commission is a non-departmental public body which must act under the general guidance of the Secretary of State, who may regulate its procedures, and give directions. The Commission began its registration functions on 1 April 2002, at which time inspectors and support staff were transferred to it from health and local authorities.

Establishments & agencies regulated by the Commission

Healthcare

- Independent hospitals (e.g., mental nursing homes)
- Independent clinics (e.g., private primary care premises where prescribed)
- Independent medical agencies (e.g., wholly private GP call-out services)
- Nurses agencies

Social care

- Children's homes
- Care homes
- Residential family centres
- Domiciliary care agencies
- Fostering agencies
- Voluntary adoption agencies

Establishments and agencies that are required to register with the Commission must have a registered owner or proprietor — the person who carries on the business — and, if that person is not in day-to-day control of it, a registered manager also. The Commission must register an applicant if it is satisfied that the applicant has demonstrated that an establishment or agency has complied with, or will comply with, all the requirements of relevant legislation and regulations. The burden of proof is on the applicant. Applications may be granted subject to such conditions as the Commission thinks fit. Any such conditions may be generic or specific. For example, conditions may be imposed that specify the categories of patients and the number of residents that may be accommodated.

Commission inspectors must regulate independent healthcare providers against national minimum standards. Inspectors and other authorised persons are given a range of powers to enable them to fulfil their statutory functions. For example, they may enter and inspect premises at any time if they are used (or believed to be used) as an establishment or agency; and they may require that they are given any information necessary to enable them to discharge their functions.

Social Services Inspectorate

The Social Services Inspectorate was established in 1985, as a professional division within the Department of Health. The Chief Inspector is the principal professional social services adviser to Ministers, and oversees the development of social care policy.

Social Services Inspectorate Functions

- Providing policy advice within the Department of Health
- Managing the Department of Health's links with social services departments and other social care agencies
- Inspecting the quality of social care services
- Assessing the performance of local councils with social services responsibilities (including 'best value')

Joint reviews are carried out with the Audit Commission. The SSI Inspection Division also undertakes a programme of national inspections in England, with the aim of evaluating the quality of social services and improving their efficiency and effectiveness. The inspectorate sets standards for each

national inspection, and evaluates the quality of services against those standards. There are currently 29 standards. Each local council with social services responsibilities receives three inspections during the five year period between SSI-Audit Commission joint reviews. One of these inspections concerns adult care services and another focuses on an area of high priority. There are also inspections of local authority inspection units, and targeted inspections in poorly performing councils.

Audit Commission

The Audit Commission was established in 1983, to perform the function of appointing and regulating the external auditors of local authorities in England and Wales. It is a non-departmental public body, sponsored by the Department of the Environment, Transport and the Regions (with the Department of Health and the National Assembly for Wales). The Commission is self-financing, and most of its income derives from the fees charged to audited bodies.

In 1990, the Audit Commission's role was extended to include the NHS. In April 2000, it was given the responsibility of carrying out best value inspections of local authority services. The Commission's remit now covers more than 13,000 bodies, which between them spend nearly £100 billion of public money each year. This amounts to around 15% of the nation's gross domestic product.

Audit Commission Functions

- To carry out best value inspections of local authority services.
- To appoint auditors to all local government and NHS bodies in England and Wales, either from its arms-length agency (District Audit) or from a pool of private firms.
- To set standards for those auditors, through the Code of Audit Practice.
- To carry out national studies designed to promote economy, efficiency and effectiveness in the provision of local authority and NHS services.
- To define indicators of local authority performance and to secure a review by auditors of each authority's arrangements for producing performance indicators.

In accordance with the NHS Plan, from 2003 onwards the Audit Commission will work with the Commission for Health Improvement (and, where appropriate, the Social Services Inspectorate) in local inspections of the implementation of national service frameworks.

Intervention by the Secretary of State

The Secretary of State has power to initiate formal and informal inquiries, and he also possesses powers of intervention in relation to health service bodies. Management of the NHS is moving to a system of 'earned autonomy', and section 13 of the Health & Social Care Act 2001 allows the Secretary of State to intervene in poorly performing NHS organisations. He can, for example, temporarily replace the board of an NHS trust. The purpose of the section is to enable him to intervene in an NHS body if he has concerns about its management, its ability to perform its functions to the required standard, or there has been a one-off catastrophe.